

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE
NCOIL SUMMER MEETING - SALT LAKE CITY, UTAH
JULY 14, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health, Long Term Care and Health Retirement Issues Committee met at the Little America Hotel in Salt Lake City, Utah on Saturday, July 14, 2018 at 8:45 a.m.

Representative Tom Oliverson, M.D. (TX), Vice Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Sam Kito (AK)	Sen. Dan "Blade" Morrish (LA)
Rep. Deborah Ferguson (AR)	Rep. Michael Webber (MI)
Sen. Jason Rapert (AR)	Rep. Joe Hoppe (MN)
Asm. Ken Cooley (CA)	Rep. Lois Delmore (ND)
Rep. Richard Smith (GA)	Rep. George Keiser (ND)
Rep. Martin Carbaugh (IN)	Asw. Maggie Carlton (NV)
Rep. Matt Lehman (IN)	Sen. Neil Breslin (NY)
Rep. Joseph Fischer (KY)	Sen. Bob Hackett (OH)
Rep. Jim Gooch (KY)	Rep. Glen Mulready (OK)
Rep. Bart Rowland (KY)	Rep. Jim Dunningan (UT)

Other legislators present were:

Rep. David Livingston (AZ)	Asw. Ellen Spiegel (NV)
Rep. Steve Riggs (KY)	Rep. Rodney Anderson (TX)
Rep. Edmond Jordan (LA)	Sen. Paul Utke (MN)
Sen. Brian Feldman (MD)	Rep. Joe Schmick (WA)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its March 4, 2018 meeting in Atlanta, GA, and its June 8, 2018 interim conference call committee meeting minutes.

DISCUSSION ON THE STATUS OF HEALTHCARE AND SHORT TERM LIMITED DURATION INSURANCE PLANS

Jan Dubauskas of IHC Carrier Solutions – Independence Holding Group, stated that IHC consists of three carriers: Standard Security Life Insurance Company of New York; Madison National Life Insurance Company, Inc; and Independence American Insurance

Company. IHC is a leader in the specialty health product segment, particularly short term limited duration insurance plans (STLDs).

Ms. Dubauskas first provided an overview of the status of the Affordable Care Act (ACA). The majority of Americans have insurance through their employers. According to the 2016 U.S. Census Bureau, of the 67.5% of Americans who have private health insurance, 55.75% is employer-based, 19.4% is through Medicaid, and 16.2% is through the direct-purchase market. The ACA has done a lot of good, but there are still 28.1 million Americans uninsured (8.8% of the population), and minorities are those impacted the most by that statistic. Ms. Dubauskas stated that from the group who has health insurance in America, 98.8% of those 65 years and older have coverage, 94.6% of children up to 19 years old have coverage, and 87.9% of those aged between 19 and 64 have coverage; 91.2% of the disabled aged 19 to 64 have coverage; 84.5% of full time employees have coverage at some point during the year, and 69% of part-time employees have coverage.

Over the past several years we have seen the number of insured increase: 271,606,000 in 2013 and 292,320,000 in 2016. The reasons for that increase has been: the ACA, Medicaid expansion, and social awareness of the importance of being insured. The Trump Administration has been very involved with healthcare, most notably by issuing an Executive Order in October directing the Department of Labor (DOL), Department of Health and Human Services (HHS) and Internal Revenue Service (IRS) to develop regulations related to association health plans (AHPs) and short term STLDs. Also, in December, the tax reform law set the individual mandate penalty to \$0.

Ms. Dubauskas noted that the final rule on AHPs was issued on June 19 and it will greatly impact sole proprietors and small businesses. The anticipated impact of the rule is that 3,600,000 people insured under the ACA will leave the ACA and 400,000 uninsured will gain coverage. The STLD proposed rule was issued on February 20 and the final rule is expected to be issued very soon. The proposed rule seeks to return the time limit of STLDs back to 364 days from its current limit of 90 days. The time limit was changed during the Obama Administration because it was concerned that too many people were purchasing STLDs instead of ACA-compliant plans. IHC's experience prior to the time limit change was that the average duration of a STLD was 4.2 months which meant that most people purchasing STLDs were doing so to fill in the gap – most likely a gap in employment. Many employers have a 90-day waiting period for health insurance to kick-in for new employees, so those in-between jobs obviously need more than 90 days of coverage.

Ms. Dubauskas also stated that the proposed STLD regulations propose a question: should STLDs be available for more than 12 months? The product is priced and developed today through underwriting to be available for 12 months so if the plans are extended beyond that time, perhaps through a renewal process, that would change the pricing and make it a different product. Accordingly, Ms. Dubauskas stated that she does not believe STLDs as written today could stay the same to accommodate that change. They would have to undergo changes including going through state insurance departments.

The proposed STLD rules also suggest changing the disclaimer language to make sure that everyone understands what they are buying and ensure that there is language indicating whether there are limitations and exclusions in the product. Ms. Dubauskas

stated that she is concerned with the fact that the disclaimer language in current STLDs is in capital letters and most people do not read language in capital letters. Also, despite the fact that agents are required to explain the product to consumers, some of the disclaimer language needs to be changed from complex insurance terms to easier to understand terms. Ms. Dubauskas stated that the anticipated impact of the STLD regulations is that between 100,000 and 200,000 people will leave the ACA and purchase STLDs, but the hope is that a high number of uninsured will purchase STLDs.

Ms. Dubauskas stated that the Centers for Medicare and Medicaid Services (CMS) has also been active in relation to the ACA. On April 9, the hardship exemptions expanded; on July 7, the risk adjuster payments were put on hold; and on July 10, the navigator funding was reduced. Ms. Dubauskas stated that due to many of the actions she discussed today, ACA premiums are going to increase. As an example, the 2019 premiums on the Maryland Health Insurance Exchange are expected to increase as follows: lowest cost bronze - \$443 (up 41%); 2nd lowest silver - \$622 (up 36%); lowest cost gold - \$606 (up 35%). The people impacted the most by those increases will be those not subject to any of the ACA's subsidies.

Ms. Dubauskas stated that she believes that with regard to the future of the ACA, the train has already left the station in that the ACA has already been irrevocably changed, and healthcare reform needs to be thoroughly discussed. Ms. Dubauskas stated that NCOIL can help by adopting a Model Law that mirrors the final STLD regulations so that there can be uniformity and efficiency for insurers and state departments of insurance.

Rep. Glen Mulready (OK) asked Ms. Dubauskas for some insight on STLDs and pre-existing conditions. If STLDs were available for those with and without pre-existing conditions, would IHC sell both? Ms. Dubauskas stated that IHC is the first company that has implemented a limited pre-existing coverage. The coverage is called Connect Plus and was released on April 19 in over 20 states. For up to \$25,000 in coverage of pre-existing conditions there is a 12-point cost differential so a STLD plan would be raised from \$100 to \$112 per month. Ms. Dubauskas noted that you still must qualify through underwriting for Connect Plus. IHC did file for and obtained approval for unlimited pre-existing condition coverage which is now required in California. IHC will begin to offer that product in CA on September 1 and the price differential is 22 points. Ms. Dubauskas stated that IHC will see how the product does in CA before rolling it out in other states, and that IHC believes that it will be attractive to those in the 40-60 age group because they are making too much money to qualify for ACA subsidies but don't want to pay \$600 per month for coverage with a large deductible.

CONTINUED DISCUSSION ON REPORTING AND NOTIFICATION REQUIREMENTS ON PRESCRIPTION DRUG MANUFACTURERS RELATED TO DRUG PRICING

Emily Donaldson of the Pharmaceutical Research and Manufactures of America (PhRMA) stated that spending for pharmaceuticals has recently slowed but patient costs have continued to rapidly increase. Policymakers are aiming to improve affordability and access and when they do that they often look to the list price of medicines for answers to the challenges that surround improving the goals of improved access and affordability. Oftentimes the legislation seen in these areas would require manufacturers to report a broad range of information in hopes that it benefits consumers. PhRMA understands why people want to see such information and that is why PhRMA has crafted a policy for consideration for NCOIL that PhRMA believes gets policymakers the information they

need from pharmaceutical manufactures in a way that protects proprietary information as recommended by the Federal Trade Commission (FTC). PhRMA also wants to make sure that policymakers are getting the full picture because there several factors that affect prices for patients and payors and they are all connected. PhRMA believes that states should implement targeted policies that will yield meaningful cost and access related information. PhRMA is serious about working with NCOIL to get this right.

Ms. Donaldson then discussed PhRMA's proposed draft policies and began by noting what is currently reported under SEC filings which are publicly available (10k filings). Manufactures currently report aggregated financial figures including total sales, the cost of goods sold, research and development (R&D), SGA expenses (selling, general, and administrative), net income or loss information, and share information. R&D is usually reported in total and sometimes there is discussion in the filings about key pipeline products in a business overview section and companies also sometimes include additional items.

States typically don't have the time or bandwidth to look through 10k filings and PhRMA understands that. Accordingly, PhRMA proposes that each year, if a state wishes to, it should identify up to 10 prescription drugs on which the state spends significant healthcare dollars and said dollars should take into account the amount of rebates. Ms. Donaldson stated that the agency identifying the drugs should have knowledge and expertise in healthcare and the pharmaceutical market such as a state health agency or an existing state commission that examines healthcare costs. The drugs identified in the list should represent different drug classes and include generics.

Ms. Donaldson then recited some of the specifics of PhRMA's proposal. For each prescription drug identified on the list, the manufacturer could report a schedule of the drug's wholesale acquisition cost (WAC) increase over the previous 5 calendar years; the manufacturer's aggregate, company-level R&D and other relevant capital expenditures for the most recent year for which final audited data is available; a written description, suitable for public release, of factors that contributed to the reported increases in WAC during the prior 5 calendar years. That information should be generally consistent with the level and type of data made available in a manufacture's 10-k filing or to other publicly available data sources. It will benefit consumers to have the information published on the collecting agency's or commission's website, but PhRMA also wants to make sure certain information is confidential and looks forward to working with policymakers on such language.

Ms. Donaldson then stated that it is important to discuss access issues in addition to price issues. Pharmacy Benefit Managers (PBMs) affect health insurance benefits which are largely state regulated and NCOIL's PBM licensure proposal could enable states to obtain greater insight and transparency into a major stakeholder in the pharmaceutical supply chain with great impact on consumer costs. PhRMA proposes that PBMs file a report each year that contains the following information: the aggregate rebate amounts that the PBM receives from all pharmaceutical manufactures; the aggregate amount of rebates not passed to health plans or issuers; and the administrative fees that the PBM receives. PhRMA looks forward to working with NCOIL to ensure that definitions are tight so that there is no shifting of definitions that would result in shifting money from one bucket to another. PhRMA believes that the aforementioned information could be published on a website so as to be made available

to consumers, but in a way that protects proprietary and confidential information for the PBMs and the people they contract with.

PhRMA also proposes that PBMs be prohibited from penalizing pharmacies or pharmacists from disclosing: cost-sharing amounts that an enrollee must pay for a particular prescription drug under or outside his/her health plan; and the existence and clinical efficacy of therapeutic equivalent drugs that would be less expensive to the enrollee both inside and outside his/her health plan.

With regard to insurers, Mr. Donaldson stated that states may also want to consider the elements of the NAIC's Model #22 – the Health Carrier Prescription Drug Benefit Management Model Act. Generally, PhRMA believes that insurers should provide electronic access to formularies and that changes to formularies should only be made after there is appropriate notice given to beneficiaries. Beneficiaries should also be able to easily access prior authorization and step therapy requirements for drugs they are prescribed and should be able to easily see the exceptions processes, along with their cost-sharing information. There should also be some form of reporting for the rates of denials and appeals for pharmaceuticals. Ms. Donaldson stated that PhRMA looks forward to working with NCOIL on drug transparency model legislation.

Caitlin Westerson of the Colorado Consumer Health Initiative (CCHI) stated that the costs of prescription drugs are going up at an unsustainable cost due to high base prices, lack of transparency in the supply chain, marketing and advertising tactics, and insurers pushing the cost on to consumers through high cost-sharing and adverse tiering which is done by putting the most expensive drugs for single disease groups on the highest tier all of the time. Ms. Westerson stated that it is important to note that such practices are a reflection of the high cost of medications, not the cause of them, but such practices do contribute to the lack of affordability of drugs that consumers are facing.

Ms. Westerson noted that the results of a March 2018 poll conducted during the last Colorado legislative session showed overwhelming support from consumers across party lines on the issue of drug pricing regulation. Connecticut and other states also conducted similar polls and the results were very similar. Some of the questions in the Colorado poll, which were similar to those asked in the others polls were: When it comes to regulating prescription drug prices to make them more affordable, do you think the government should be doing more, doing less, or about the same they are doing now? (76% said doing more); the CO Attorney General should have the power to investigate whether a pharmaceutical corporation is artificially inflating the cost of prescription drugs and medications, and taking advantage of patients who rely on their medications (agree or disagree – 89% agreed); Would you support or oppose a legislative proposal that would require prescription drug corporations to notify the public if they plan to increase the price of a drug by 10% or more? (85% supported); Would you support or oppose a ballot initiative that would require prescription drug corporations to disclose how they come up with the prices of their prescription drugs, including how much they spend on manufacturing, production, research and development, advertising, and what their profit margins are? (84% supported)

Ms. Westerson stated that the main takeaway from the polls is that consumers want action and they want the pharmaceutical and insurance industries, and the supply chain in between, to be held accountable. Ms. Westerson stated that in the Colorado 2018 legislative session there were several bills introduced to address the cost of prescription

drugs, one of which is similar to the proposals outlined by Ms. Donaldson that did not pass. Other bills focused on creating a wholesale importation program around price gouging and on PBM gag clauses which did pass. Prior to the 2018 legislative session, Colorado has done work in the regulatory space to address tiering and non-discriminatory benefit design issues as well as permitting biosimilars to be substituted by biologic drugs which is not a huge part of the market right now but will be in the future.

Ms. Westerson stated that it is important to note that federal policymakers are in a better position to bring down the overall price of drugs given the existing patent laws and market-exclusivity protections, but, it is unclear at this time what federal efforts will look like and how quickly they can be adopted so state action on these issues is imperative. Ms. Westerson stated that during the time since the NCOIL Health Committee last met in March and discussed the California and Vermont drug pricing transparency laws, Oregon has enacted a similar law.

Ms. Westerson then noted some things that state policymakers can do to combat rising drug prices and promote transparency. One policy is to prohibit price gouging for all drugs which requires drug companies to justify their price increases or face penalties – this approach has been adopted in Maryland. Another policy is to create a drug price review commission which essentially functions as “rate review” for prescription drugs and is similar to what health insurance carriers are required to do on an annual basis. Ms. Westerson noted that the drug pricing transparency laws in CA, OR and VT are similar in intent but slightly differ in substance and stated that a Model drug pricing transparency Model Law would help to standardize the process in states.

Ms. Westerson stated that another policy is to limit or ban drug manufactures from offering gifts to physicians which is a practice called “detailing” whereby drug representatives meet face to face with prescribers and the research shows that such meetings have an impact on what drugs are being prescribed and pushing consumers to higher cost drugs. Another policy option is to provide public funding for evidence based academic “detailing” programs where physicians would still get the same educational information but not in a manner that encourages them to change their prescribing practices in a negative way. Pennsylvania has enacted that policy in its Pharmaceutical Assistance Contract for the Elderly (PACE) program and it has yielded some savings on drug spending.

One policy option that is focused on the insurance industry is limiting or prohibiting coinsurance as coinsurance puts a big burden on consumers, especially those living with chronic disease, and drug prices can change from month to month and paying a percentage rather than a fixed fee makes it difficult for consumers to budget accordingly. Some states (DE/LA/MD) have eliminated coinsurance and capped co-pays at somewhere between \$150 - \$200. Another school of thought is to cap co-pays at 1/12 of the out-of-pocket maximum so that your health insurance carrier still gets the same amount of money but the cost to the consumer is spread through the 12 months of the plan year rather than front-loading it in January or February for people with high cost medications. Another policy option focused on the insurance industry is to prohibit discriminatory formulary designs which has been enacted in DE, CA and CO. Said policy prohibits insurers from placing all or most drugs that treat a specific condition on a single tier. Ms. Westerson stated that she believes many of the policy options can be used in developing an NCOIL drug pricing transparency model law.

Ms. Westerson stated that there are some policy proposals that are concerning to consumers such as those that would cut prescription drug benefits, increase copays, and restrict the use of new and expensive medications. Anything that limits access for consumers is ultimately going to result in higher healthcare costs down the road due to higher emergency room use and hospitalizations.

Ms. Westerson stated that there are some other important questions to consider when developing a drug pricing transparency model law. Do existing state agencies have the authority to request data and enforce non-compliance? In Colorado, there is no existing state agency that has the authority over pharmaceutical manufactures, PBMs, or other entities in the supply chain. Does the state have the infrastructure and funding to analyze the data collected? Do states have a single-subject rule? Colorado has a single subject rule so enacting reform around the entire supply chain is difficult. Do you need legislation? Some states have regulatory structures that would better lend themselves to drug pricing transparency reform. Ms. Westerson closed by stating that it seems that it is the first time all of the “players” are sitting down at the same table offering ways to lower costs and that CCHI looks forward to working with NCOIL moving forward.

Rep. Steve Riggs (KY), NCOIL Immediate Past President, asked for examples of discriminatory formulary design. Ms. Westerson stated that it happens most frequently with HIV and AIDS medications when all of the drugs that are used to treat those diseases are put on the highest tier so there are no lower cost options for consumers.

Sen. Brian Feldman (MD) noted that Maryland’s price gouging law was struck down by the 4th Circuit and litigation is pending, and asked Ms. Donaldson how a Model drug pricing transparency would function given that states such as CA, OR and VT have laws in place that call for more transparency than what Ms. Donaldson proposed in her earlier remarks. Ms. Donaldson stated that PhRMA has concerns with laws that require advance notification of certain drug price increases as such a policy gives distributors the opportunity to stockpile drugs at a lower price and then sell them at a higher price which can cause drug shortages. With regard to a Model Law, Ms. Donaldson stated that she does not believe every state is going to approach these issues how PhRMA would like them to. Sen. Feldman stated that his point is that if CA already has a law enacted that goes further than the Model’s approach, he does not think CA would adopt the Model. Ms. Donaldson agreed that CA may not adopt such a Model but noted that the CA law is currently being litigated. Ms. Donaldson also noted that in Oregon, while they may not “go back” on the law they passed, the Oregon Governor has implemented a Task Force to look at other stakeholders in the drug supply chain and what additional steps need to be taken to receive transparency from those stakeholders.

Rep. Joe Schmick (WA) asked Ms. Westerson if the policy proposals she outlined have been enacted long enough to know whether or not they have been effective. Ms. Westerson stated that the policies discussed that focus on marketing practices and reducing cost-sharing have been in-place for two years, if not longer, while the policies discussed that focus on reducing power over drug pricing and increasing transparency in the supply chain have mostly been in-place for about two to three years. There has been a lot of academic writing on the “rate review” commission proposal, but no state has enacted it. Rep. Schmick asked if there have been positive results in the states that have enacted the abovementioned reforms. Ms. Westerson replied yes - the states that prohibit coinsurance or cap co-pays have seen a reduction in consumer out-of-pocket spending but that is really the relationship between consumers and health insurance

carriers so there is not much relief in the overall system because the insurers are still paying the full price or their negotiated rates for the drugs. PA has also seen savings due to its funding for evidence based academic “detailing” programs but that is only implemented through its PACE program which focuses on low-income seniors.

Rep. Tom Oliverson, M.D. (TX), Vice Chair of the Committee, stated that the only “detailing” that is left exists in the pharmaceutical industry which relates to free samples of drugs in doctor’s offices, and rebate booklets, which benefits patients. Rep. Oliverson asked Ms. Westerson if discussions surrounding aggregate rebate information, rebates not being passed to the consumer, and list prices, actually get the consumer off the bench and into the market to shop around, as he is not sure that such discussions do. Rep. Oliverson also asked what state lawmakers can do to encourage consumers to be more participatory in the process of shopping around as he does not see a concerted effort in the healthcare industry to provide information in a format that is understandable for the average consumer the way it is provided for consumers with auto insurance, life insurance, or 529 plans.

Ms. Westerson stated that passing rebates through to consumers would help in addition to things like a “plan cost-finder tool” which is currently on the Colorado health insurance exchange website. Using that tool, consumers find plans that cover specifically what they need in addition to getting estimates for out of pocket spending. The tool is not a direct-dollar amount, but it will give the consumer a low, middle, and high estimate of what they can expect to pay. Ms. Westerson stated that legislation is probably not needed to implement such a tool and it would facilitate the shopping experience.

Ms. Donaldson stressed the importance of cost-sharing fairness which entails the pass-through of rebates, and part of PhRMA’s policy proposal seeks to ensure that insurers or PBMs are in some way certifying that at least a majority of rebates are being passed through to consumers. PhRMA’s policy proposal also has several options for the issues depending on how far a state wants to go. Ms. Donaldson also reiterated that PhRMA believes that insurers should provide electronic access to formularies and that changes to formularies should only be made after there is appropriate notice given to beneficiaries. Beneficiaries should also be able to easily access prior authorization and step therapy requirements for drugs they are prescribed and should be able to easily see the exceptions processes, along with their cost-sharing information. There should also be some form of reporting for the rates of denials and appeals for pharmaceuticals. All of that information should also be available to those shopping for plans, not just current enrollees.

Rep. Jim Dunnigan (UT) stated that changing to a fixed dollar co-pay does not lower costs. It gives the consumer certainty but that may not be good. As an example, under one of the plans offered in Utah the employer can choose a plan that has a 25% co-pay or a \$25 co-pay for preferred brand-name drugs. That means for anything less than \$100, you are better off with a percentage co-pay. Rep. Dunnigan asked where the incentive is for consumers to shop to get the best pricing on drugs if they are going to pay \$20 no matter where they obtain the drug. Ms. Westerson agreed that a fixed dollar co-pay does remove the incentive to shop around but what makes it difficult when shopping for health insurance and drug coverage is that the consumer is at the will of what the carrier covers so shopping around may not be as easy as it seems when factoring in physician’s networks. Colorado passed a regulation that requires plans to offer some plans that are co-pay only, in addition to plans with coinsurance. For those

with chronic diseases that need to spread the cost throughout the year, they can choose the co-pay only plan, while those that may not prioritize drugs as high could choose the coinsurance plan. The regulation has seemingly worked fairly well, and notably, the co-pay was capped at 1/12 of the out-of-pocket maximum so the consumer is ultimately paying the same amount of money throughout the year and they are just able to spread it throughout the year rather than front-loading it.

Rep. Dunnigan stated that he is focused on the situation of once the consumer has the prescription, if there is a fixed dollar co-pay the consumer will go wherever and there is no incentive to shop. Ms. Westerson stated that she was speaking to the shopping experience before a consumer is enrolled in a plan. Once they are enrolled, Ms. Westerson agreed with Rep. Dunnigan that the fixed dollar co-pay eliminates incentive to shop. Ms. Westerson noted that she is not sure how much shopping around can be done in certain states. Colorado has a large rural/urban divide and in many rural communities there is only one pharmacy.

Rep. Dunnigan asked if passing rebates through to consumers lowers overall costs or only costs for that consumer. Ms. Westerson replied that it lowers costs for that consumer. Rep. Dunnigan stated that is a problem since overall costs are not lowered. If the rebates are currently going to the employer and factored into their overall rate and renewal, then passing the rebates to the individual employee raises the renewal rate for everyone else, which is not necessarily wrong, but overall costs have not been lowered. Ms. Westerson agreed and stated that something needs to be done regarding listing prices which is hard to tackle at the state level and is more so linked to the federal regulatory structure.

Sen. Bob Hackett (OH) asked how to solve the problem of consumers making informed decisions only to then see the formulary changed. Ms. Donaldson clarified that manufacturers would not be the ones changing formularies. Ms. Westerson stated that it would be great to see consumers purchasing plans knowing that their drug is covered and the formulary is not changed for the plan-year. There have been efforts in states to eliminate mid-year formulary switching but the concern is that if you have a certain group of drugs that are locked-in for a plan-year, what happens when the prices of those drugs are raised and insurers are stuck in a situation where they cannot change.

Before moving onto the next topic on the agenda, Rep. Mulready clarified a statement made yesterday regarding the opioid epidemic and the business practices of Walmart. It was presented that if someone wants to go to another pharmacy that information goes into the prescription drug monitoring system (PDMP) and it therefore shows them as pharmacy-shopping. Rep. Mulready stated that is not the way the system works. When someone shows up with a prescription, the information only goes into the PDMP when the prescription is filled.

DISCUSSION ON IDAHO'S HEALTHCARE MARKETPLACE REFORM PROPOSALS

Dean Cameron, Director of the Idaho Department of Insurance, stated that Idaho, like many other states, is struggling with the effects of the ACA. Prior to the ACA, Idaho had some of the lowest rates in the nation and had \$150 million worth of claims and \$175 million worth of annual premium, but those numbers rose to \$600 million worth of claims and \$545 million worth of annual premium. The worst disparity resulted in carriers losing \$130 million in one year. Idaho has had three consecutive years of increases greater

than 24% in premiums and last year the increase was 28%. Consumers in Idaho are being forced out of coverage and Idaho is starting to lose carriers as well. Idaho has been fortunate to have had five carriers participating in its state-based exchange from its inception, but now the number is down to four and two of the four are considering reductions in their footprint.

Dir. Cameron stated that Idaho has a population of approximately 1.7 million and about 250,000 of them are without coverage, an increase of approximately 60,000. Idaho is losing the young and the healthy from its insured population because they can no longer afford coverage, and because of the unfair rules of the ACA, they do not qualify for any subsidies. Many of them are going without coverage and for many states, they end up on catastrophic health rolls, indigent care rolls, and end up increasing property taxes. Some are looking to STLDs like a couple in Twin Falls, Idaho, aged 62 and 63, who could no longer afford the \$1,300 per month premium so they purchased a STLD for \$700 per month, and they will hop from one STLD company to another until they reach the age of 65. The tough part is that they are not receiving any benefit for any pre-existing conditions because each STLD they get resets coverage. Some are also looking to faith-based programs, but the problem is that such programs are not regulated by the dep't of insurance and are not held out to be insurance. The Idaho Insurance Dep't is starting to see a higher number of complaints relating to faith-based programs as consumers struggle to see their claims paid.

One consumer in Idaho needed a liver transplant, but the faith-based program stated that it would not cover the procedure because she had drunk alcohol at some point in her life. Another consumer was told by a faith-based program that they were not sure that her faith matched the tenants of the program's faith and denied coverage. Idaho is also seeing consumers turn to direct primary care arrangements. Dir. Cameron stated that he has no problem with faith-based programs or direct primary care arrangements, but they are not comprehensive, long term health insurance. A fundamental tenant of all insurance is a reasonable mix of healthy individuals with those with less-healthy conditions. The ACA changed the rules and those with less-healthy conditions came in droves while forcing the healthy out.

Idaho decided that something needed to be done and the approach started with Governor Butch Otter issuing an Executive Order directing Dir. Cameron to look for less expensive non-ACA compliant plans. Idaho needed to find ways to attract the healthy back into the marketplace and in order for it to be effective, Idaho could not just offer a plan that would compete with the ACA to attract the healthy back into the same risk-pool. In January, the Idaho Dep't of Insurance issued Guidance on its proposals and had worked upfront with all carriers. The Guidance was designed to follow Idaho law, as well as some provisions of federal law. Interestingly, as soon as Gov. Otter's Executive Order was issued, the Idaho Insurance Dep't received lots of national criticism and attention which was somewhat surprising because those criticizing had not read the Dept's Guidance because it had not yet been issued. Once the Guidance was issued, some, but not all, of the criticism disappeared. The fundamental fear that persisted was a state not following the ACA.

Dir. Cameron then discussed some of the main provisions in the Guidance. First, it is important to understand that in Idaho, in order to market a state-based non-ACA compliant plan, you must also market an ACA-compliant plan in the same geographic area. It is also important to understand that state-based plans must be part of the same

risk-pool as ACA-compliant plans; and because those plans are in the same risk-pool, the rates are tied together so as an ACA plan rises, so does the non-ACA plan. One area of ACA non-compliance stated under the Guidance was that plans were required to cover the majority of essential health benefits (EHBs), the only exclusions being maternity coverage (provided that the majority of the carrier's plans offered such coverage), and pediatric, dental, or vision coverage. A second area of ACA non-compliance stated under the Guidance was to go back to the 5:1 age slope. The ACA required a 3:1 slope which many believe was a protection for seniors, but it wasn't. Idaho can produce data showing that whether a 5:1 or 3:1 slope is used, the price for seniors is the same – it is young adults who get hit hardest. A 21-year-old on a 3:1 slope pays about \$270 per month for coverage in Idaho and that same plan under a 5:1 slope would be \$89 per month.

A third area of ACA non-compliance stated under the Guidance was that Idaho plans had a provision based on state law that required a 12-month pre-existing condition clause provided that the consumer came with no previous coverage. Most people did not understand that the ACA has a waiting period. If you go to enroll in an ACA-plan outside of open enrollment, you must wait until open-enrollment or figure out some special exclusion as to why you can avoid that. So most people, when going to buy coverage who had developed a condition and did not have prior coverage, already had a waiting period.

The Guidance also sought to allow plans to have an annual limit of \$1 million, however, if the consumer hit that number, they would automatically be transferred to an ACA-plan so they would not see any change or reduction in benefits. The Guidance also sought to permit plans to have different out-of-pocket maximums because consumers were saying there was no magic in the number \$7,350 and some preferred to have a \$10,000 or \$15,000 maximum, especially when they are healthy and not in need of additional coverage. Lastly, the Guidance permitted plans to underwrite in order to determine the appropriating rating. Consumers could not be denied coverage and the rates were not higher than ACA-plans so said plans became the ceiling. Some concerns were raised that such a practice would raise rates for those with ACA-plans, but data was able to be produced that showed that was not the case.

Dir. Cameron stated that shortly after the Guidance was issued, one carrier stepped forward, wanted to follow the guidance, and provided the Dep't with five plans which actually covered maternity and had a 4:1 slope. Shortly after that carrier filed rates with the Dep't, the Dep't received a letter from CMS. Most of the media portrayed the letter as a cease and desist letter but it was not, although it was an unusual approach from CMS because the Dep't had been having conversations with CMS prior to the letter and had received positive feedback from them. Also, Dir. Cameron stated that he was not aware of CMS having ever taken action prior to plan approval, and CMS usually reviews a state's body of work, not individual plans.

Dir. Cameron stated that the ACA calls for states to substantially enforce the law and stated that words mean everything in legislation so why would Congress put the word "substantially" in the ACA statute unless Congress anticipated some states to deviate from the ACA in some way. In fact, typically, when Congress passes legislation it does not tell states that they must enforce it – enforcement is assumed. Dir. Cameron stated that the Dep't asked CMS what "substantially" means, and it is interesting to note that under the Obama Administration, in keeping with President Obama's promise that you

would be able to “keep your plan,” the Administration used the “substantially” enforce language in order to allow people to keep their transitional or grandfathered plans. The Administration also used the “substantially” enforce language to allow the labor unions to keep their plans. Dir. Cameron stated that Idaho is substantially enforcing the ACA. Dir. Cameron further stated that in the multiple conversations between the Dep’t and CMS, the Dep’t is acquiescing too much as the Dep’t has agreed to do away with the provisions regarding annual limits, EHBs, pre-existing conditions, and underwriting. Dir. Cameron stated that the Dep’t will continue to work with CMS.

Rep. Schmick (WA) asked what the permissible rating factors were for underwriting in the Guidance. Dir. Cameron stated that the factors were age, tobacco use, and geography, and noted that the ACA permits a health risk assessment for group plans. The Guidance proposed using the factors from the ACA group plan health risk assessment so that a carrier could provide for some sort of credit off of the insurance such as a credit for quitting smoking, joining a fitness club, or managing diabetes. Such practices get close to underwriting, but it is not underwriting as consumers cannot be denied coverage. Dir. Cameron stated that a consumer who is not healthy may be better off with an ACA plan, but a healthy consumer, in order to get them back into the Idaho marketplace, has to be offered products and discounts in order to do so.

Rep. Jim Gooch (KY) stated that it is important to understand that young people will not buy insurance and pay an inflated rate for it when they don’t think they need it. The compression of rating bands is key, and some policies had a 7:1 ratio. Moving to a 3:1 ratio probably did help seniors slightly but there is no question that when you compress from 7:1 to 3:1 you are more than doubling the price for young people and then when you also include coverage that they don’t need you are forcing them out of the market. Rep. Gooch further stated that unlimited lifetime maximums are better than a plan with a \$2 million or \$3 million maximum, but a young person may not need that unlimited lifetime maximum because they are going to a different job or some other reason. Rep. Gooch applauded Dir. Cameron’s efforts in Idaho.

CONTINUED DISCUSSION ON DRAFT NCOIL PBM LICENSURE AND REGULATION MODEL ACT

Sen. Jason Rapert (AR), NCOIL President, stated that the Committee members may be overwhelmed with comments and suggestions on the draft NCOIL PBM Licensure and Regulation Model Act (draft Model) but that is not a bad thing because the goal is to produce a Model that addresses one of the most significant issues affecting costs in the healthcare market arena that we face in our nation and it is wrapped up in many different issues. Sen. Rapert stated that 13 organizations have voiced support for the draft Model, including the American Medical Association (AMA). Sen. Rapert stated that after this meeting, he hopes the Committee members can review all of the material submitted in order to judiciously consider all suggestions and comments to produce the best possible Model.

Sen. Rapert stated that he is not trying to put forth the recently enacted Arkansas PBM law as a national Model law, rather, his goal is to produce a Model that can be a chassis for states to use in developing their own PBM laws. That means one state may want a different set of tires or a different CD player in their chassis, but Sen. Rapert stated that the one thing that he does want in the Model that many seem to agree on is licensure of PBMs, regulation of PBMs, and enforcement through a common regulator in the states

that would provide a stabilizing factor to address these contentious issues. Sen. Rapert then mentioned the recent news regarding the Kentucky Department of Insurance issuing an Order of Civil Penalty and Probation against PBM CaremarkPCS Health, LLC for multiple violations of the Kentucky Insurance Code, and the recent news regarding Ohio Governor John Kasich and Ohio Attorney General Mike DeWine announcing that a consultant hired by the Ohio Department of Medicaid discovered that the PBMs are getting three to six times the usual market rate. CVS Caremark and OptumRX are the two PBMs in the Ohio Medicaid program.

Sen. Rapert stressed that PBMs play a significant and important role in the drug supply chain, but when there are bad actors involved and there are a small number of actors that control over 78% of the market, and you see some of the revelations in the news, it is clear that there are issues that need to be addressed. Sen. Rapert stated that the current draft of the Model is essentially the Arkansas PBM law but there are provisions of the Model that he is willing to amend. The Arkansas PBM law is being used as the starting point for drafting an NCOIL Model because the Arkansas PBM law is the most expansive PBM law in the nation. Sen. Rapert also noted the recent ruling from the 8th Circuit (*PCMA v. Rutledge*) that struck down the Arkansas Maximum Allowable Cost (MAC) statute as being preempted by ERISA, which is included in the draft NCOIL Model, and stated that he is open to adjusting that section of the Model to ensure that the Model is not constitutionally problematic for states.

Joshua Keepes of America's Health Insurance Plans (AHIP) stated that AHIP's primary interest in the draft Model is that AHIP's member's contract with PBMs on a regular basis because they bring tremendous value to not only health plans but to Medicaid agencies, employers, unions, and state employee programs by keeping costs down, using evidence-based care, and improving medication adherence. Mr. Keepes stated that AHIP's proposed amendments to the Model serve to build upon Sen. Rapert's main goal of having a referee in place, but AHIP believes that some provisions in the Model should be removed as the cost of them does not equate to the value they would provide. AHIP's proposed amendments rely mainly on consensus-based approaches from different states, and provisions that have already been enacted and discussed by stakeholder groups. AHIP's proposed amendments also seek to simplify and streamline some of the Model's regulatory provisions.

Mr. Keepes stated that AHIP believes its proposed amendments help protect and enhance collaboration between health plans, PBMs and pharmacists. Such collaboration provides value not only to health plans but to consumers at the pharmacy counter by keeping pharmacy costs low, and in a broader systemic point of view, keeping health insurance premiums low. AHIP hopes that their amendments have removed some duplicative requirements in the draft Model. AHIP believes that many state protections already exist in certain areas that the draft Model addresses such as network adequacy. Mr. Keepes stated that AHIP also wants to protect the experience and expertise that PBMs bring to the table for health plans.

Mr. Keepes further stated that AHIP's proposed amendments also seek to address the issue of drug pricing transparency, and the proposed language is based on the recent law passed in Oregon. AHIP understands that NCOIL is considering that issue in a separate Model but AHIP believes that the issue goes hand in hand with discussions regarding PBMs, and AHIP thinks that rising prescription drug costs, which now account for 23 cents of every health insurance premium dollar, is something that must be

addressed. The equation of prescription drug benefits and prescription drug costs is incomplete without that analysis. AHIP looks forward to discussing drug pricing transparency requirements moving forward.

Mr. Keepes stated that AHIP's proposed amendments also seek to create a more level playing field by ensuring that in the contracting and regulatory processes, all parties come to the table without any thumbs on the scale. The proposed amendments focus on the role of private contractual arrangements and AHIP believes that the best way to address many of the issues that the Model seeks to resolve is to do so through the contracting process and without state intervention. Mr. Keepes noted that AHIP's proposed amendments regarding licensure and regulatory requirements are based on an enacted Tennessee law and were discussed by a large set of stakeholder groups. Similarly, AHIP has proposed changes to the MAC section of the draft Model which have been discussed and agreed upon by a large set of stakeholder groups. By using such consensus language, AHIP hopes to avoid any discrepancies or disagreements as the draft Model is discussed by the Committee and in states. Mr. Keepes stated that AHIP looks forward to continuing the discussions surrounding the Model and it is important to find a balance between consumer protection and keeping costs low.

Melodie Shrader of the Pharmaceutical Care Management Association (PCMA) stated that PBMs exist to work as a vendor for health plans. Health plans put together the benefit and PBMs administer that benefit. PBMs negotiate rebates, provide clinical tools to ensure adherence, and build networks with pharmacies. Ms. Shrader stated that referees enforce rules, but they are not the rule makers, and that is PCMA's major concern with the draft Model – it is taking legislator's responsibility to develop rules and abdicating it to the regulators. PCMA looks forward to working with NCOIL to ensure that the Model sets forth the appropriate rulemaking authority to the legislators who have been elected by the citizens of their states.

Ms. Shrader stated that PCMA is very concerned the MAC section of the draft Model as it mirrors the Arkansas MAC statute which was recently ruled by the 8th Circuit as preempted by ERISA. Ms. Shrader also noted that between now and the NCOIL Annual Meeting in December, PCMA will welcome NCOIL to participate in a webinar that will discuss the 8th Circuit's ruling, and ERISA in general. Ms. Shrader acknowledged Kentucky's PBM licensure and regulation law, as well as the recent news regarding the Kentucky Insurance Dep't issuing an Order of Civil Penalty and Probation against PBM CaremarkPCS Health, LLC. Ms. Schrader stated that it appears that the Kentucky law is working which is a good thing and that CaremarkPCS Health will have an opportunity to appeal.

Ms. Shrader stated that the situation in Arkansas was unique and the conversation was initially dominated due to changes in its Medicaid program. Arkansas' Medicaid program is a product on the Arkansas exchange and last year many of the exchange products had rate increases. In healthcare, when you push one way, something comes out the other end and that is what happened in Arkansas since there was a structured benefit and a structured number of dollars which resulted in rate cuts. Ms. Shrader noted that doctors are used to losing money in Medicaid, so their voice was not heard a lot in Arkansas, but the pharmacists certainly raised their voice.

Ms. Shrader stated that PCMA is not here to just say "no" and PCMA looks forward to looking at provisions in several state PBM laws to include in the Model so that the Model

can in fact be a chassis for states to use when they encounter unique situations relating to PBMs. Ms. Shrader noted that Florida recently passed a PBM licensure law that, among other things, sets forth a referee and prohibits gag clauses which is something that PCMA supports as customers should always pay the lowest price at the point of sale. The FL law also has a MAC section that PCMA believes would not be challenged. PCMA looks forward to continuing the dialogue on the Model between now and December.

Ronna Hauser of the National Community Pharmacists Association (NCPA) stated that it is important to note that the number of independently owned rural pharmacies declined by 12.1% between 2003 and 2013. The number of retail pharmacies that were the only pharmacy in their community declined steadily between 2003 and 2009. There are currently only approximately 1,800 pharmacies serving as the sole provider in their community. Those statistics are from the Rural Policy Research Institute. Ms. Hauser stated that based on those statistics, it is vital that those healthcare providers remain in business and provide care to their patients at a local level. Unfortunately, their existence is threatened by certain PBM tactics and regulation of PBMs is sorely lacking. As the sole entity in the entire drug supply chain responsible for deciding which drugs your doctor can prescribe, which drugs you can take, which pharmacy you can go to, how much the drugs cost, and how much providers get paid, common sense regulation such as licensure, enforcement and audit authority is desperately warranted.

Ms. Hauser stated that today, PBMs control the pharmacy benefits of more than 253,000,000 Americans. After numerous acquisitions and consolidations, just 3 PBMs control 78% of prescription drug benefit transactions in the U.S. Since the advent of PBMs, there has been a 169% increase in consumer out-of-pocket drug costs. During that same time, PBM profits have soared, begging the questions that both federal and state elected officials are asking: what is the true role of PBMs related to soaring drug costs? How do we best regulate them? Where are the savings they tout going? NCPA believes that the draft Model is a very positive step in the right direction to address those unanswered questions.

Ms. Hauser stated that PBM licensure and regulation is not duplicative or unnecessary. PBMs have argued, and courts have ruled, that health insurer regulations do not apply to PBMs. The public must be protected from PBM misconduct. In states where PBM regulations have been implemented, there have been issues with enforcement, in part because pharmacies feel contractually prohibited from contacting the Insurance Cmsr. or other oversight entities to report issues. Ms. Hauser noted that AHIP's comments on the Model request that such pharmacist protections be removed from the Model. Ms. Hauser closed by stating that NCPA strongly supports the Model and that NCPA's suggested amendments will put the Insurance Cmsr. in a better position to regulate PBMs. NCPA looks forward to continuing the discussions surrounding the Model between now and December.

Rep. Dunnigan stated that the section in the Model that allows the pharmacist to decline providing pharmacist services to a patient if the pharmacist is not getting reimbursed enough to cover the drug concerns him. Rep. Dunnigan stated that if he goes to a pharmacist with 3 prescriptions and the pharmacist only fills two of them because only two are profitable, that does not seem to benefit the consumer, particularly when consumers are often anxious to get the prescription to start using it. Ms. Hauser stated that she shares Rep. Dunnigan's concerns and it is unfortunate that in the current

environment in which pharmacists practice in, that they are filling many prescriptions under-water. However, by their nature, pharmacists are going to provide care to their patients. Ms. Hauser stated that NCPA is open to discussing and compromising on the section Rep. Dunnigan references.

Rep. Joseph Fischer (KY) stated that he has not read the aforementioned 8th Circuit opinion yet but asked that since most of the work of PBMs is related to group health plans, what is the limit of state's authority to license and regulate PBMs. Ms. Shrader stated that the 8th Circuit opinion said that the business of insurance is regulated by states, so states can put certain requirements on health plans regarding their risk pooling activity. Ms. Shrader stated that if an employer is based in Texas and has employees in both Texas and Arkansas, ERISA wants to make sure that the administration of that health plan is seamless. The 8th Circuit opinion supported that notion and stated that the PBM's contract needed to be consistent with that approach. Ms. Shrader noted that ERISA has a number of limitations regarding state authority and PCMA typically only challenges state laws that are egregiously preempted by ERISA. PCMA has not challenged the Florida law. Ms. Hauser stated that it is important to note that the 8th Circuit's opinion only applies to the 8th Circuit and that case dealt with several provisions of the Arkansas MAC statute being preempted by ERISA and Medicare Part D. However, the provisions of that MAC statute still apply to non-ERISA and non-Medicare part D plans. Ms. Shrader agreed but stated that it is important to note that the only plans the MAC statute will apply to now are those in the individual market and in Arkansas they would be sold on the exchange.

Sen. Rapert stated that the Arkansas PBM law was drafted to consolidate disparate things that have been done to try and address the many issues Arkansas was experiencing with PBMs. The 8th Circuit opinion only dealt with Arkansas' MAC statute which is overseen by the Arkansas Attorney General's Office. The only reason the MAC statute was included in the Arkansas PBM law was because of an effort to bring together all of Arkansas' approaches in dealing with PBMs into one law. Sen. Rapert noted that all of the other sections of the Arkansas PBM law remain intact despite the MAC statute being ruled as being preempted. Sen. Rapert also noted that dealing with ERISA in state legislation is very tricky and even mentioning ERISA in certain legislation can be problematic and grounds for being preempted. Sen. Rapert further stated that NCOIL may be the proper forum to have discussions about ERISA impeding upon the ability of state regulation. Sen. Rapert closed by reiterating his earlier comment that he is open to amending the Model with regard to the MAC section because it does no good to offer a Model to states that will be constitutionally problematic. Rep. Fischer asked if the 8th Circuit opinion only struck down the Arkansas MAC statute. Sen. Rapert replied, yes, and stated that there was not a lawsuit on the Arkansas PBM law, rather, the lawsuit was only focused on the Arkansas MAC statute.

Rep. George Keiser (ND) stated that PBM contracts with pharmacists are binding and confidential and asked Ms. Shrader if PCMA would support opening up the definitions section of contracts for legislators and the public. Ms. Shrader stated that she believes that would be an individual company issue and could not answer that question without conferring with PCMA's members. Rep. Keiser stated that North Dakota is somewhat ahead with a lot of the issues the Model seeks to address and noted that one contract in North Dakota with a PBM defines "specialty drugs" arbitrarily as the 10 most prescribed drugs in the state and that specialty drugs could only be filled by mail-order which obviously has serious implications for local pharmacies. Rep. Keiser stated that

definitions should not be proprietary and if you cannot see the definitions you cannot understand what is happening in the contracts. Sen. Rapert clarified that Rep. Keiser's statements did not address any provisions in the Model but rather focused on whether PCMA was willing to consider some North Dakota approaches relating to PBM contracts.

Asm. Ken Cooley (CA), NCOIL Secretary, stated that ERISA was signed into law by President Gerald Ford in the 1970s and the nature of health plans as understood back then is not how health plans function today. Asm. Cooley stated that state legislators hold the power of their citizenry to think about the future and to enact laws to impact the future. Asm. Cooley stated that he is concerned that artful lawyering has caused ERISA to evolve into something that was not in President Ford's contemplation when he signed it into law. Asm. Cooley agreed with Sen. Rapert's earlier statement that it may be time for NCOIL to discuss ERISA as a whole so that everyone can understand how it has evolved into what it is today, and an opportunity can be provided for state legislators and interested parties to ask questions about the proper role of ERISA in relation to the system of federalism. Rep. Oliverson agreed with Asm. Cooley. Rep. Deborah Ferguson (AR) stated that ERISA should not stand in the way of state legislators tackling the issues states are experiencing with PBMs, and echoed Asm. Cooley's, Sen. Rapert's, and Rep. Oliverson's statements regarding further discussing ERISA.

Sen. Hackett stated that there has been a large movement recently towards self-funded plans which ERISA regulates. Sen. Hackett stated that rebates are a contractual arrangement, but no one knows the amount of the rebates and that causes many to speak out against them. Sen. Hackett asked how to increase transparency while maintaining that contractual relationship. Mr. Keepes stated that from a health plan perspective, they are faced with the decision of whether the rebates should be distributed at the point of sale at the pharmacy counter or put back into the health insurance premium to lower the premiums for an entire plan. Ms. Shrader agreed with Mr. Keepes and stated that 90% of all rebates go back to the client and it is up to the client to decide where to distribute them. The role of the PBM is to negotiate the very lowest price on drugs available, whether through rebates or through simply PhRMA lowering prices. Sen. Hackett asked if Ms. Shrader could state that no rebates are kept by the PBMs. Ms. Shrader repeated that 90% of all rebates go back to the client, but that does not mean that the PBMs keep 10% on every contract as it is a negotiated item in every contract.

Sen. Feldman asked Sen. Rapert if Arkansas has considered asking for an *en banc* rehearing of the 8th Circuit case *PCMA v. Rutledge*. Sen. Feldman encouraged Arkansas to do so since the issues involved in the case are very important to many other states. Sen. Rapert stated that a decision has not been made yet. Ms. Shrader stated that *PCMA v. Rutledge* was a unanimous 3-0 decision and it was based on a prior 8th Circuit decision, *PCMA v. Gerhart*, which was also a unanimous 3-0 decision.

Rep. Matt Lehman (IN), NCOIL Treasurer, applauded Sen. Rapert for getting involved in the issues surrounding PBMs but stated that the real issue is the price of pharmaceutical drugs. Rep. Lehman stated that too many times states look to the federal government to solve problems but that is not the solution and the problems with the ACA is an example of that. Rep. Lehman stated that he looks forward to further discussing the Model but noted that pharmaceutical manufacturers and companies need to be part of all discussions going forward in order to hear from all sides to properly address all the issues

Sen. Rapert stated that he appreciated the discussions held today but clarified that, despite noting the issues with the Arkansas MAC statute, he has not agreed to any specific amendments to the Model yet. Sen. Rapert then referenced an op-ed written by Garth Reynold, Executive Director of the Illinois Pharmacists' Association, that notes how PBMs provide valuable services but that more than a third of the list price of brand medicines ends up going back to PBMs and other supply chain members, according to a recent study by the Berkeley Research Group.

The op-ed states that those savings rarely reach patients. Many insurance plans require patients to pay coinsurance on drugs, or a pre-determined percentage of the drug's cost. The problem, though, is that many beneficiaries' out-of-pocket spending is based on the drug's full list price, not the negotiated price secured by PBMs. As an example, a patient's heart disease medicine has a list price of \$100. Her insurance requires her to pay 40 percent of that price, or \$40. But the PBM negotiated a rebate of 30 percent on the list price, making the actual price of the medicine \$70. The patient still pays \$40, which means that she's paying 57 percent of the medicine's real price — not the 40 percent to which she agreed. Or consider a patient whose insurance plan requires him to pay \$20 copays on all of his prescription pills, regardless of the pills' price. If the PBM negotiated a price that's less than \$20, the patient still pays \$20. The PBM simply keeps the savings for itself. With pricing strategies like this, it's no wonder why PBMs are joining forces with giant pharmacy chains; there's a lot to be said for the efficiency offered by an existing, giant customer base. Already, CVSHealth and Rite Aid act as their own PBMs.

Sen. Rapert stated that those examples are an echo of what is heard across the country. Sen. Rapert compared the issues before the Committee to asking owners of local hardware stores to sell a shovel for less than the cost of the shovel and then castigating the owner for not selling the shovel at that cost. Sen. Rapert stated that is simply not good policy. Sen. Rapert noted that many business and industries don't want the curtain to be lifted on certain business practices because such practices have made those businesses and industries into the powerhouses that they are today. Sen. Rapert then disagreed with some of PCMA's statements made in its comment letter such as: NCOIL propose model act puts safety & access to needed medications at risk; NCOIL proposed model act puts patient safety at risk; NCOIL model act ignores existing regulations; NCOIL proposed model act grants excessive rulemaking authority; and NCOIL proposed model act removes free market incentives.

Sen. Rapert stated that he supports free markets but does not support licenses to steal, and that he wants to see transparency, whether in this Model or a sperate drug pricing transparency model. When prescription drug costs account for 23 cents of every health insurance premium dollar, there is clearly a problem. Sen. Rapert stressed again that not all PBMs are bad actors. Sen. Rapert stated that he is starting to feel some consensus around certain issues and that one or two interim committee conference calls may be needed to further discusses some issues, but that NCOIL is perfectly positioned to provide a chassis to deliver to states for them to use to calm the waters in this arena.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:00 a.m.